



# **Texas Department of Insurance**

## **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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### **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

#### **GENERAL INFORMATION**

**Requestor Name**

ELITE HEALTHCARE NORTH DALLAS

**Respondent Name**

FREESTONE INSURANCE CO

**MFDR Tracking Number**

M4-14-2835-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

MAY 14, 2014

#### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "almost all of the claims on this patient have been PAID IN FULL. See the attached ledger showing such. Please note, this patient had preauthorization and **PER RULE 134.600, the carrier shall not withdraw preauthorization once issued.** See attached preauthorization letter...Dates 11/25/13, 1/2/14, 1/29/14, 2/19/14 were denied due to extent. The patient went to a CCH and lost on extent on 2/13/14. See attached CCH results. Therefore, these dates have been **amended with the diagnosis pointer in box 24e addressing the accepted diagnosis.**"

**Amount in Dispute:** \$1,761.25

#### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The provider's request was not date stamped as received by DWC MRD until 5/14/14. Consequently, it is not timely as to the DOS prior to 5/13/13...carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

#### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2012 March 28, 2013	CPT Codes 97112-GP (X2), 97110-GP (X2)	\$203.88 \$217.47	\$0.00
January 4, 2013 January 18, 2013 February 1, 2013	CPT Code 99213-25	\$4.97 \$0.39 \$0.39	\$0.00
February 15, 2013 September 27, 2013 January 2, 2014 January 29, 2014 February 19, 2014	CPT Code 99213-25, 99080-73	\$134.22 \$134.22 \$129.45 \$129.45 \$129.45	\$134.22
August 1, 2013	CPT Code 97140-GP (X2), 97112-GP (X2), 97110-GP (X4)	\$418.26	\$418.26
October 9, 2013	CPT Code 97002-GP	\$69.18	\$0.00

November 25, 2013	CPT Code 99214-25, 99080-73	\$189.92	\$0.00
TOTAL		\$1,761.25	\$567.48

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
5. 28 Texas Administrative Code §134.600 requires preauthorization for specific health care treatment and services.
6. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
7. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
8. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
9. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 216-Based on the findings of a review organization.
  - 50-These are non-covered services because the payer does not deem this.
  - 56-Significant, separately identifiable E/M service rendered.
  - 246-This non-payable code is for required reporting only.
  - 219-Based on extent of injury.
  - 4280-This procedure code requires a functional reporting G code to be billed.

#### **Issues**

1. Does a timely filing issue exist in this dispute?
2. Does an extent of injury issue exist?
3. Does a medical necessity issue exist? Is the requestor entitled to reimbursement?
4. Was payment for services rendered on September 27, 2013 in accordance with fee guideline? Is the requestor entitled to reimbursement?
5. Are the disputed services eligible for medical fee dispute resolution?

#### **Findings**

1. 28 Texas Administrative Code §133.307(c) (1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are November 15, 2012 through February 19, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on May 14, 2014. Dates of service prior to May 14, 2013 are later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section for dates of service prior to May 14, 2013; consequently, the requestor has waived the right to medical fee dispute resolution for these dates.
2. The respondent denied reimbursement for services rendered on October 9, 2013, November 25, 2013, January 2, 2014, January 29, 2014 and February 19, 2014 based upon denial code "219".  
The February 13, 2014 Contested Case Hearing decision found that "The compensable injury of September

19, 2011 does not extend to or include disc bulges/protrusions/herniations at L3 through S1 with radiculopathy. Claimant did not have disability during the period beginning February 19, 2013 through the date of hearing.”

A review of the medical records for the disputed services finds that treatment was to the lumbar spine and lower extremity; therefore, the treatments in dispute were rendered for an injury, which the parties agreed, was not compensable according to the Contested Case Hearing decision as discussed above. The requestor rendered health care to this injured employee for the non-compensable lumbar spine; therefore, no reimbursement can be recommended for the services in dispute rendered on October 9, 2013, November 25, 2013, January 2, 2014, January 29, 2014 and February 19, 2014.

3. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code “50-These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.”

On July 12, 2013, the respondent’s representative Injury Management Organization gave preauthorization for two sessions of physical therapy, CPT codes 97110, 97112, and 97140 to be rendered from July 12, 2013 through August 11, 2013. The respondent did not submit any documentation to support that the requestor had exceeded the preauthorization for services rendered on August 1, 2013.

28 Texas Administrative Code §134.600(I) states, “The insurance carrier shall not withdraw a preauthorization or concurrent review approval once issued.” The Division concludes that a medical necessity issue does not exist and the requestor is due reimbursement for physical therapy services rendered on August 1, 2013.

Per 28 Texas Administrative Code §134.203(c) (1) (2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year’s conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year’s conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 55.30.

The Medicare Conversion Factor is 34.023.

Review of Box 32 on the CMS-1500 the services were rendered in Dallas, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Dallas, Texas.

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Total Amount Paid	Total Amount Due
97140-GP (X2)	\$30.27	\$49.20 X 2 = \$98.40	\$0.00	\$98.40
97112-GP (X2)	\$33.72	\$54.81 X 2 = \$109.62	\$0.00	\$109.62
97110-GP (X4)	\$32.34	\$52.56 X 4 = \$210.26	\$0.00	\$210.26
TOTAL DUE				\$418.28, requestor is seeking \$418.26

4. The respondent indicated on the explanation of benefits that payment was issue for the office visit and report rendered on September 27, 2013; however, the requestor noted that payment was never received. The respondent to support that service was paid submitted no proof; therefore, payment is due per fee guideline.

Using the above formula, the MAR for the office visit, CPT code 99213, is \$119.22. This amount is recommended for reimbursement.

In addition to the office visit, the requestor billed for a work status report, CPT code 99080-73.

28 Texas Administrative Code §134.204 (l) states “The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).”

28 Texas Administrative Code §129.5(i)(1) states “Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section.” Therefore, the requestor is due \$15.00 for the work status report.

5. The requestor has failed to support that the disputed services rendered on November 15, 2012, January 4, 2013, January 18, 2013, February 1, 2013, February 15, 2013, March 28, 2013, October 9, 2013, November 25, 2013, January 2, 2014, January 29, 2014 and February 19, 2014 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$567.48.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$567.48 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

07/30/2014  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**